

## Proposals to Slow Growth of Federal Health Spending Focus on Medicare and Medicaid

*The rapid growth of Federal health spending has prompted legislative proposals to control Medicare and Medicaid expenditures. The proposals will affect rural communities because the Medicare and Medicaid programs provide health insurance for over one-fourth of the nonmetro population.*

**R**eal Federal spending on health grew rapidly between 1990 and 1995, increasing from \$207 billion to \$307 billion in constant 1995 dollars (fig. 1).<sup>1</sup> By 1995, health programs accounted for one-fifth of the entire Federal budget, and there was growing concern about the effect of health spending on the budget deficit. Congress has begun considering legislative measures to slow the growth of spending on the Medicare and Medicaid programs, which are responsible for the bulk of Federal health expenditures. The proposed measures have important implications for rural communities because the two programs provide health insurance for 26 percent of the nonmetro population.

### Most Federal Health Programs Provide Personal Health Care

The Federal government supports a wide variety of health-related activities, but 92 percent of Federal health spending pays for personal health care through programs run by three Cabinet Departments. Some Federal health programs serve individuals entitled to care under existing legislation, while others target populations without adequate health services. Programs for individuals include Medicare for the elderly and disabled and Medicaid for the poor (both run by Health and Human Services), plus separate health care systems for veterans (run by Veterans Affairs), military personnel and dependents (run by Defense), and Native Americans (run by Health and Human Services). Programs that target populations include the National Health Service Corps and Community Health Centers serving residents of designated underserved areas, and Migrant Health Centers serving migrant farmworkers and their families (all run by Health and Human Services).

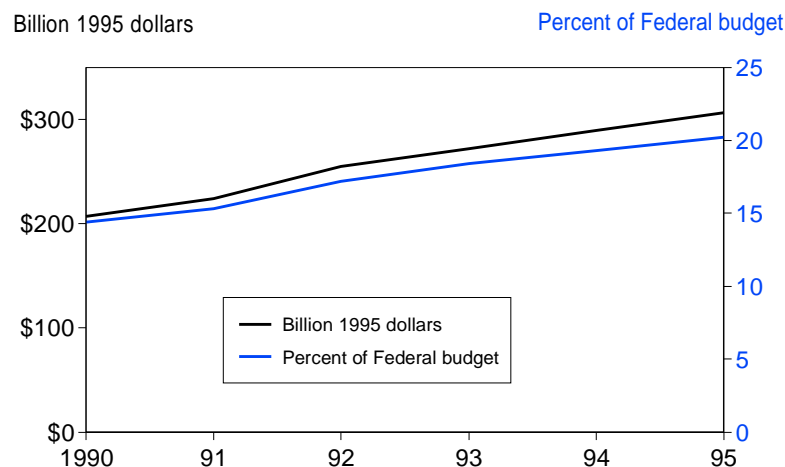
This review focuses on how proposed legislative changes in the Medicare and Medicaid programs might affect rural communities. Medicare and Medicaid accounted for 88 percent of Federal health spending in 1995 and covered 74 million persons. Other Federal health care programs may also face funding changes, but serve much smaller populations than Medicare or Medicaid.

<sup>1</sup> References to years in this article are fiscal years in the case of Federal expenditures, and calendar years in all other cases.

Figure 1

### Growth of Federal health spending, 1990-95

*One-fifth of the Federal budget was spent on health in 1995*



Source: Calculated by ERS from the Budget of the United States Government.

### Medicare Covers Relatively More Persons in Nonmetro than Metro Areas

Medicare provides subsidized health insurance for the elderly aged 65 or older and certain nonelderly disabled persons under age 65. The program is financed by Social Security taxes, general Federal revenues, and monthly premiums paid by Medicare beneficiaries, who were liable for 24 percent of the total cost of health services covered by Medicare in 1995. Federal Medicare expenditures rose 11 percent during 1995 to \$180 billion, accounting for nearly 12 percent of the Federal budget.

Medicare covered about 38 million persons in 1995, including 34 million elderly and 4 million nonelderly disabled persons. Nonmetro residents are more likely to have Medicare than metro residents because nonmetro residents are more likely to be elderly or disabled (table 1). Estimates from the March 1995 Current Population Survey (CPS) for the noninstitutional population (excluding persons in nursing homes and other institutions) indicate that 16 percent of nonmetro residents and 12 percent of metro residents had Medicare in 1994. Less recent enrollment statistics reveal that Medicare covered 20 percent or more of the total population in many nonmetro counties in the Midwest and Great Plains with high proportions of the elderly (fig. 2). Only a few metro counties had comparably high proportions of Medicare beneficiaries.

Nonmetro health care providers are more dependent on Medicare revenue than metro providers due to the higher proportion of Medicare beneficiaries in nonmetro areas.

Table 1

#### The Medicare program

*Nonmetro residents are more likely to have Medicare than metro residents*

Item	Metro	Nonmetro
	Percent	
Eligibility:		
(1) Proportion of elderly persons aged 65 or older, 1990	11.9	14.7
(2) Proportion of disabled persons unable to work among persons aged 16-64, 1990	3.8	5.6
Program beneficiaries:		
(3) Proportion of Medicare beneficiaries, 1994	12.2	15.8
	Dollars	
(4) Median income of Medicare beneficiaries, 1994	17,960	15,547
	Percent	
(5) Proportion of Medicare beneficiaries below poverty level, 1994	12.4	16.5
	Dollars	
Finances:		
(6) Average Medicare expenditure per beneficiary, 1992	3,937	3,191
	Percent	
(7) Proportion of physician gross practice revenue from Medicare, 1994	26.7	33.1
(8) Proportion of community hospital net patient revenue from Medicare, 1993	33.5	38.8

Sources: (1)-(2) 1990 Census of the United States; (3)-(5) ERS estimates from March, 1995 Current Population Survey; (6) Rural Policy Research Institute; (7) American Medical Association; and (8) American Hospital Association.

Medicare payments accounted for a larger share of physician gross practice revenue in nonmetro areas (33 percent) than metro areas (27 percent) in 1994. Medicare payments also represented a larger share of community hospital net patient revenue in nonmetro areas (39 percent) than metro areas (33 percent) in 1993.

The average Medicare expenditure per beneficiary was 19 percent lower in nonmetro areas (\$3,191) than metro areas (\$3,937) in 1992. The difference was due to the lower Medicare reimbursement rates for health care providers in nonmetro areas, as well as different patterns of health care use by metro and nonmetro beneficiaries.

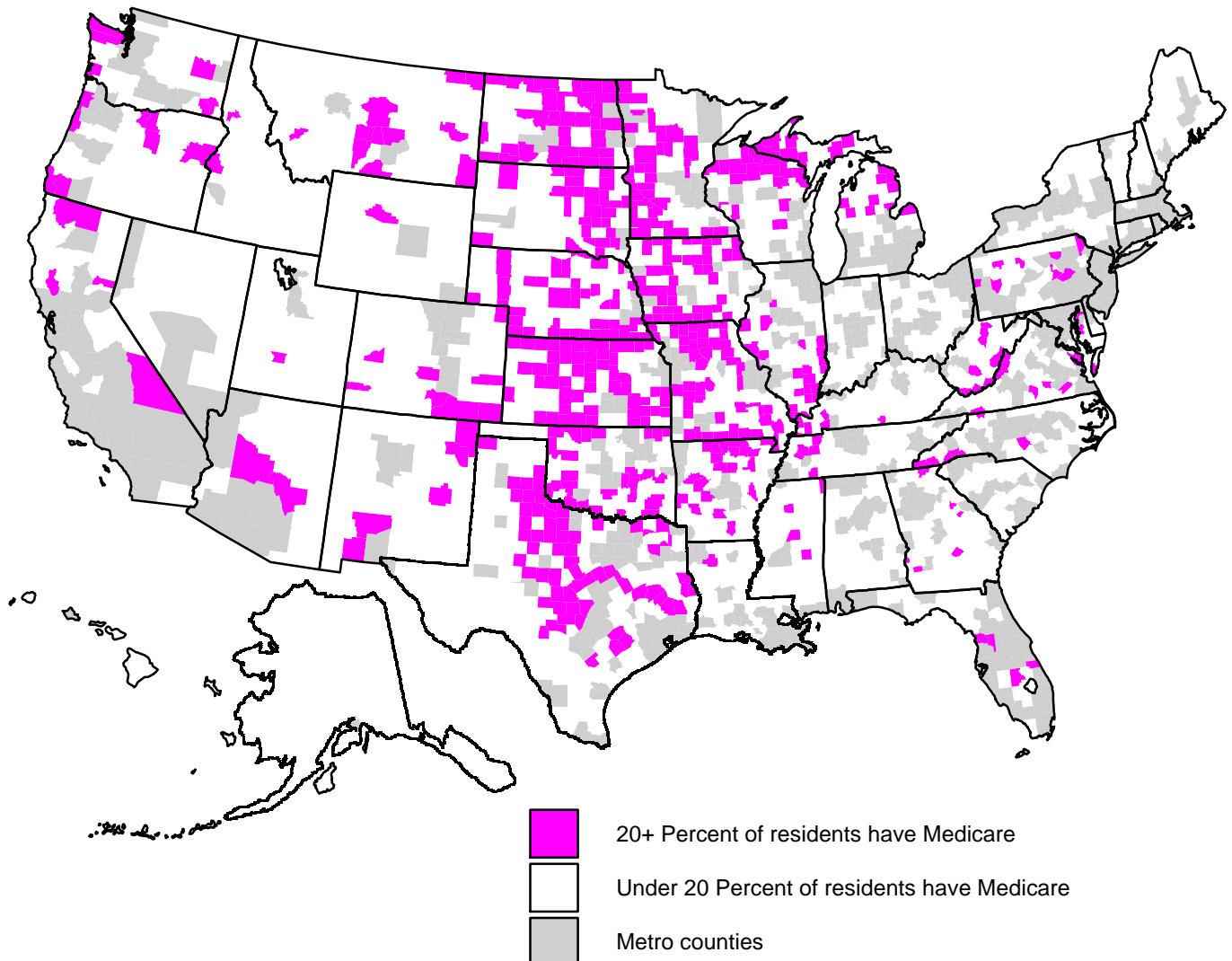
### Proposed Changes in Medicare Will Affect Beneficiaries and Providers

Legislative proposals to slow the growth of Federal Medicare spending include (1) increasing the share of costs paid by Medicare beneficiaries, (2) reducing the growth of Medicare payments to health care providers, and (3) enrolling more beneficiaries in man-

Figure 2

### Nonmetro counties with a high proportion of Medicare beneficiaries, 1991

*Medicare covered one-fifth or more of the nonmetro population in many areas of the Midwest and Great Plains*



Source: Calculated by ERS from Area Resource File data.

aged-care plans in the expectation that plans will provide health care at lower cost than traditional fee-for-service arrangements.

A general increase in cost sharing for Medicare beneficiaries will have a greater financial effect on nonmetro than metro beneficiaries because nonmetro beneficiaries have lower incomes. The March 1995 CPS indicates that median income was 13 percent lower for nonmetro beneficiaries (\$15,547) than metro beneficiaries (\$17,960) in 1994. Conversely, increases in cost sharing limited to high-income beneficiaries will probably affect relatively fewer nonmetro than metro beneficiaries.

Reductions in the projected growth of Medicare payments to health care providers may disproportionately affect nonmetro providers, who are more dependent on Medicare revenue than their metro counterparts. The effect on nonmetro providers will depend on how payment reductions are allocated among different categories of providers. Under current legislation, some categories of providers receive extra Medicare payments, including Sole Community Hospitals serving rural communities with only one hospital and physicians practicing in designated Health Professional Shortage Areas. Payment reductions could also affect the general population if Medicare hospital payments fall further below hospital costs for treating Medicare patients, forcing hospitals to shift additional unreimbursed costs to private patients or local taxpayers in the case of communities where public hospitals provide uncompensated care.

Proposals to enroll more Medicare beneficiaries in managed-care plans have focused on providing a wider choice of plans for beneficiaries. Measures that make managed-care plans more widely available could affect relatively more nonmetro than metro beneficiaries because nonmetro areas are less well served by plans than metro areas. However, the expansion of plans may also increase price competition among health care providers, threatening the financial viability of nonmetro providers whose ability to discount fees is limited by low patient volumes or profit margins.

### **Medicaid Covers Same Proportion of Metro and Nonmetro Residents**

Medicaid is a combined Federal-State program to provide medical assistance for specific categories of the poor, including the elderly, disabled, and families with dependent children. The program is administered by individual States with the Federal government paying part of the costs under a matching formula based on State per capita income. In 1995, the Federal share of Medicaid costs ranged from 50 percent (in 13 States and the District of Columbia) to 79 percent (in Mississippi). Total Federal Medicaid costs rose 9 percent to \$89 billion in 1995, accounting for nearly 6 percent of the Federal budget.

About 41 million persons were enrolled in Medicaid at some time during 1995, including nearly 2 million residents of nursing homes and other institutions. March 1995 CPS estimates indicate that there was no significant difference in the proportion of the noninstitutional population with Medicaid in metro areas (12 percent) and nonmetro areas (13 percent) in 1994 (table 2). Prior to 1994, Medicaid covered a higher proportion of nonmetro than metro residents. The disappearance of the metro-nonmetro difference in 1994 was associated with a decline in the nonmetro poverty rate.

The new welfare law enacted in August 1996 changed some aspects of the Medicaid program. The law terminated the Aid for Families With Dependent Children (AFDC) program that had determined Medicaid eligibility for poor families, but requires States to continue providing Medicaid for those meeting July 1996 AFDC eligibility standards. The law also allows States to deny Medicaid to most legal immigrants already in the U.S., and requires States to exclude most future legal immigrants from Medicaid for 5 years following their arrival. March 1995 CPS estimates indicate that Medicaid covered about 3 million non-citizens in 1994, nearly all in metro areas.

Medicaid covers only a minority of the poor because families with employed persons are generally ineligible for program participation. The March 1995 CPS indicates that Medicaid covered similar proportions of the metro and nonmetro poor in 1994 (table 2). Estimates from the March 1994 CPS based on a larger sample reveal that the nonmetro

poor were least likely to have Medicaid in a large region including 10 Central States (fig. 3). A higher proportion of nonmetro poor adults were employed in the Central States (67 percent) than in other States (51 percent) in 1993, reducing Medicaid enrollment in the Central States due to the restrictions on coverage of families with workers.

Physicians derived a larger share of their gross practice revenue from Medicaid patients in nonmetro areas (16 percent) than metro areas (11 percent) in 1994. In contrast, nonmetro community hospitals received a smaller share of net patient revenue from Medicaid (11 percent) than metro hospitals (13 percent) in 1993. The geographic variations in physician and hospital revenue suggest that nonmetro Medicaid enrollees use relatively more physician services but fewer hospital services than metro enrollees, perhaps because nonmetro enrollees are less likely to visit hospital emergency rooms for non-emergency care.

There are large variations in Medicaid expenditures between States due to differences in medical benefits, reimbursement systems, the health status of enrollee populations, and other factors. In 1995, average Medicaid expenditures per recipient of medical assistance ranged from \$1,891 in Tennessee to \$7,276 in New York. (Arizona had lower expenditures than Tennessee, but the exact amount spent in Arizona was unavailable.)

### Effect of Changes in Medicaid May Vary by State

Legislative proposals to slow the growth of Federal Medicaid expenditures initially included (1) setting annual limits on Federal Medicaid spending and (2) converting Federal matching funds into block grants to allow States to determine Medicaid eligibility and benefits. The State governors subsequently proposed that some categories of the poor remain automatically eligible for Medicaid benefits, including the elderly, pregnant women, and children under age 13.

The effect of annual limits on Federal Medicaid spending may vary by State, depending on whether States increase their own Medicaid spending, restrict the number of persons eligible for coverage, or reduce benefits to compensate for the new spending constraints. The effect on nonmetro areas will consequently depend on how individual States respond. Some States may regard the health needs of the nonmetro poor as a more important funding priority than other States.

Table 2

### The Medicaid program

*Metro and nonmetro residents are equally likely to have Medicaid although poverty is greater in nonmetro areas*

Item	Metro	Nonmetro
Percent		
Eligibility:		
(1) Proportion of persons below poverty level, 1994	14.6	16.0
Program enrollees:		
(2) Proportion of Medicaid enrollees, 1994	12.4	12.7
(3) Proportion of Medicaid enrollees among persons below poverty level, 1994	48.8	44.0
Finances:		
(4) Proportion of physician gross practice revenue from Medicaid, 1994	10.5	16.1
(5) Proportion of community hospital net patient revenue from Medicaid, 1993	12.9	11.4

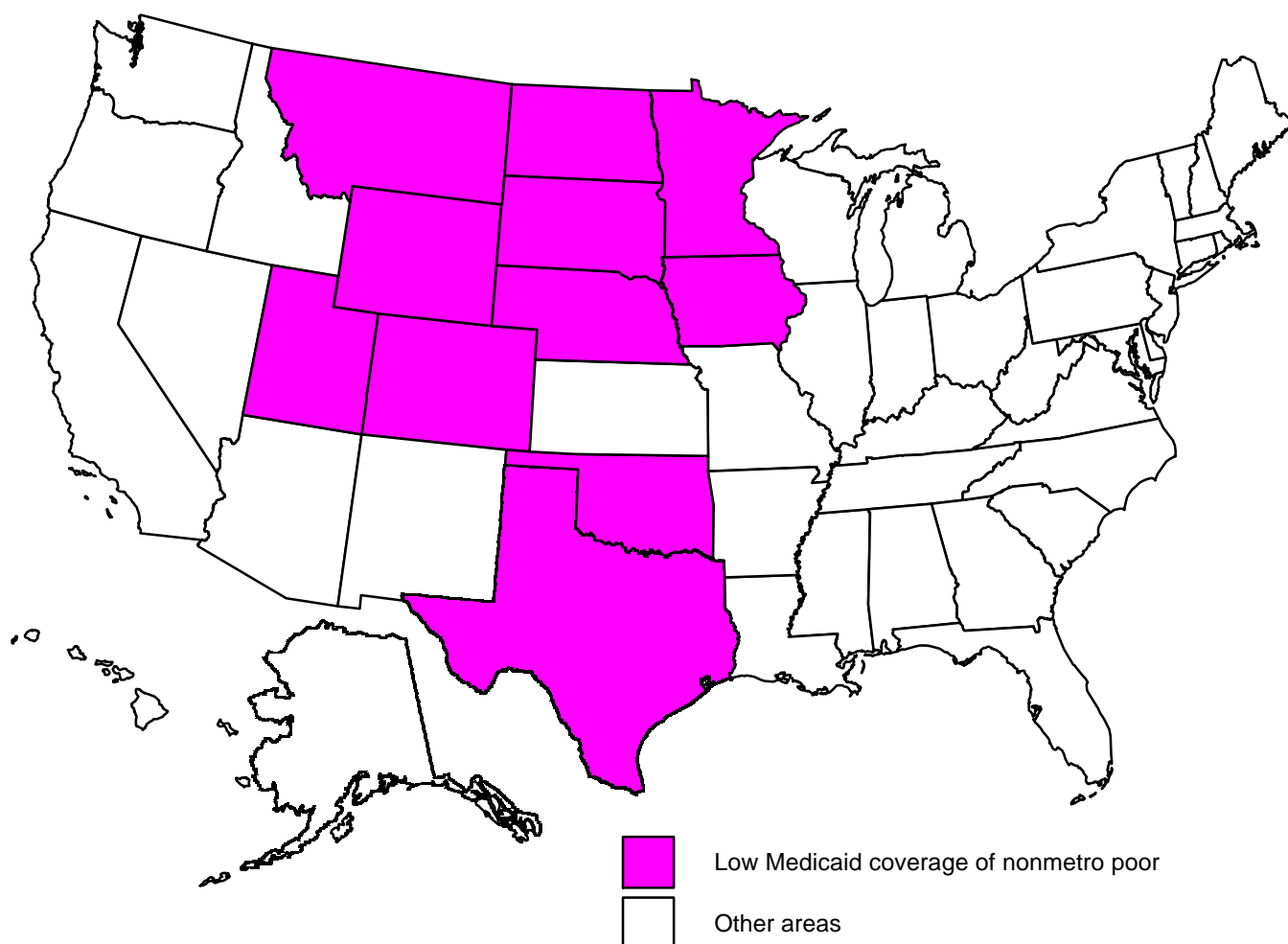
Sources: (1)-(3) ERS estimates from March 1995 Current Population Survey; (4) American Medical Association; and (5) American Hospital Association.

The conversion of Federal matching funds into block grants would give States more authority over Medicaid eligibility standards and benefits, even if some of the poor remain automatically eligible for coverage. It is difficult to predict how individual States might use the new powers provided by block grants, but States are unlikely to expand eligible populations or increase benefits in view of current efforts to limit public spending. [Paul D. Frenzen, 202-501-7925, pfrenzen@econ.ag.gov]

Figure 3

### Regional variations in Medicaid coverage of the nonmetro poor, 1993

Only 29 percent of the nonmetro poor had Medicaid coverage in a large region covering 11 Central States



Source: Calculated by ERS using data from the March, 1994 Current Population Survey.